RURAL HOSPITAL PERFORMANCE IMPROVEMENT

Mississippi Delta Region

Hospital Performance Improvement Initiative (HPII) – Mississippi River Delta Region
Annual Progress Report
September 12, 2001 – September 29, 2002

Contract Number: 250-01-0047

Deliverable Item Number: _____

Deliverable Item Delivery Due Date: Annual

Date of Submission: December 27, 2002

Five (5) copies

TO:
Office of Rural Health Policy
Attn: Jerry Coopey, Project Officer
HRSA, DHHS
Parklawn Building, Room 9A-55
5600 Fishers Lane
Rockville, MD 20857

FROM:
Terry Hill, Project Director
National Rural Health Resource Center
600 East Superior Street, Suite 404
Duluth, MN 55802

Mountain States Group, Inc.
(as the contracting agency)
1607 W Jefferson
Boise, ID 83702

_____
Terry Hill, Project Director

Requirement from the HRSA contract for the Hospital Performance Improvement Initiative for the Mississippi River Delta Region:

Section C Descriptions / Specifications / Work Statement

B. Description & Scope of Work

General Requirements

I. Tasks to be Performed in the First Year

Task 9: Meet Reporting Requirements

The Contractor shall submit the following reports to the PO:

An annual progress report which includes (1) summary of activities carried out during the year, and (2) an accounting of costs, and (3) a description of activities planned for the next year.

This first annual progress report for the Rural Hospital Performance Improvement (RHPI) Project of the Mississippi Delta Region is for the first contract year, September 12, 2001 through September 30, 2002. This progress report responds to the project contract #250-01-0047, and provides (1) a summary of activities carried out during the year, and (2) an accounting of costs, and (3) a description of activities planned for the next year, according to the reporting requirements.

Four quarterly reports previously submitted to the Project Officer provides greater detail on project progress.

(1) A SUMMARY OF ACTIVITIES CARRIED OUT DURING THE YEAR

The project established three goals for this project:

1. Provide assistance to approximately 25 hospitals in the Mississippi Delta Region.
2. Develop tools that can be used with rural hospitals to improve performance.
3. Build regional, state and local capacity to provide technical assistance to rural hospitals.

Summary of activities to meet goal 1 – Provide assistance to approximately 25 hospitals in the Mississippi Delta Region:

- Ten comprehensive consultation were scheduled in seven of the Delta states.
- Nine comprehensive consultations were conducted (the tenth consultation was canceled after some preparatory work was done, due a change in hospital management).
- Thirteen targeted consultations were started during the first contract year.
- Three of the targeted consultations were completed during the first contract year (Ferrell IL, Caldwell KY, Sharkey MS) the remaining will be continued into and completed in the second contract year.
- Eight hospitals participated in the project's employee satisfaction survey; reports were delivered to these hospitals.

- Nine hospitals received assistance through manuals and guides, including the CEO Recruitment Guide, Patient Satisfaction Surveys for Critical Access Hospitals, Conducting Hospital Employee Satisfaction Surveys, and Recruiting for Retention – Primary Care Providers. Follow-up was conducted with all nine hospitals by telephone regarding the use and usefulness of the guides and manuals.

Summary of activities to meet goal 2 – Develop tools that can be used with rural hospitals to improve performance:

- It was recognized early in this contract year that there are many tools already available. The project revised this goal to include the collection of tools.
  - A web site was developed and existing tools included.
  - There are currently 40 downloadable tools on the Delta RHPI Project web site.
  - 18 tools can be ordered from other agencies and 10 tools are available through links to other web sites
- Resource coordination is part of building capacity and project staff and consultants work to provide information, resources and materials to hospitals through the web site and as part of follow up.

No new tools were developed in Year 1, although substantial work was accomplished on developing at least 4 tools including a tool for assessing kidney dialysis.

Summary of activities to meet goal 3 – Build regional, state and local capacity to provide technical assistance to rural hospitals:

- State meetings were held in all eight states of the Delta Region; though mostly informational meetings, this was the start of building capacity at the state level.
- Consultations in rural hospitals provide an opportunity to build capacity at the hospital and community levels.
- A total of seven state partners, offices of rural health and hospital associations, have participated in consultations. The participation in these consultations start as informative and can then lead to building capacity. (State people participated in Cross Ridge AR, Milan TN, Methodist-Fayette TN, Lawrence AR, Humphreys MS, North Sunflower MS, Hamilton IL). At least five states are working toward supporting the hospitals following the RHPI Project consultations (Mississippi, Illinois, Kentucky, Tennessee, Arkansas).
- Three of the eight states – Illinois, Mississippi and Alabama – either held or planned to hold at state conference on performance improvement. Other states expressed an interest in doing so some time in 2003.

(2) AN ACCOUNTING OF COSTS

See attached spreadsheet for year-end report.

(3) A DESCRIPTION OF ACTIVITIES PLANNED FOR THE NEXT YEAR

On August 5 and 6, 2002, the project team met to plan for contract year two. The results of this meeting are summarized below.

- It was determined to continue with 10 comprehensive hospital consultations and to 7-8 targeted consultations. Additional hospitals may be reached with educational programs/presentations (e.g., technical skills, use of tools, etc.).
- Efforts will focus on building a regional hospital performance database and providing education to build capacity in the area of data collection and analysis.
- Look into building state and local PI capacity through workshops and/ or modules.
- Balanced Score Card and benchmarking efforts were planned, initially in a limited capacity. Additional financial resources will be necessary to do more extensive performance measurement and database development.
- Need to leverage hospitals that have already participated in the project to market the project to other eligible hospitals.
- Revise the evaluation plan to make it achievable; investigate alternative evaluators; and modify the employee satisfaction survey.
- Arrange for a conference call with key consultants participating in targeted consultations to provide 1) project information and update, 2) specific training on a selected topic, 3) an opportunity for consultants to interact with each other, and 4) share information, tools, consulting experience to add value to this project.
- Utilization of a professional writer to pull together the project's first year successes for a publishable paper and marketing effort.
- Continue to distinguish the RHPI Project from other Delta projects while at the same time partnering with other Delta projects. Inform hospitals about the community networking project in their county.
- Formal plan for conducting follow up and support to participating comprehensive consultation hospitals. There are o current plans for targeted consultation hospitals.
- Increase the time on site for comprehensive consultations to meet hospital needs. Include a day spend on site meeting with hospital board.
- Better define the community assessment process in the comprehensive PI consultations. Analyze existing community heath data, suggest and provide community assessment tools and identify community assessment resources in that state.
- Ensure the tools are developed to support the project are available on a pre-determined time schedule.

Note: A regional project conference was held October 2002, which was early in the second year. Significant information was shared at this conference regarding performance improvement and the Balanced Scorecard. This is considered the kick off for the BSC pilot project conducted in two Delta hospitals. More will be reported in the first quarter report for the project's second contract year.

The remainder of this progress report follows the format used for the quarterly reports and summarizes the contract year according to the four quarterly reports submitted to the Office of Rural Health Policy.

1) STATUS OF THE HPI INITIATIVE

General Requirements
All work done under this contract shall be done under the general guidance and monitoring of the Project Officer. The Contractor shall arrange: (1) monthly conference calls with the PO; and (2) quarterly conference call with PO and Advisory Committee. The Contractor shall provide the necessary services, qualified personnel, supplies, materials, equipment and facilities, not otherwise provided by the Government under the terms of this contract, as needed to perform the tasks as set forth below. Specifically, the Contractor shall fulfill the objectives of this contract by performing the tasks listed below.

The project director and the project officer are in regular and frequent contact via telephone calls and conference calls, exceeding the general requirement for conducting monthly conference calls. Quarterly conference calls with the project officer and the advisory committee began following the third project quarter establishment of the project advisory committee (see Task 2).

I. Tasks to be Performed in the First Year
To accomplish the goals of this project, the Contractor shall conduct the following tasks.

Task 1: Employ Competent Staff
The Contractor shall employ knowledgeable staff to develop, implement and manage the Hospital Performance Improvement Initiative (HPII) for the Mississippi River Delta Region. This shall include a Project Director to provide overall direction and management of this contract. This individual must have (1) senior-level executive experience in rural health; (2) managed projects providing technical assistance and other resource services; and (3) demonstrated the ability to work with small and rural hospitals. The Project Director's resume shall be included with the proposal. The Contractor shall employ other staff in numbers as necessary to carry out the functions of this contract.

The project team, including staff and contracted experts were in place during the first quarter of this project. The contract administrator, Hartzell Cobbs, became more involved in the project as it became apparent of the need for additional administrative support for this project. As the executive director of Mountain States Group, Hartzell's role was also the contract's administrator. Terry Hill served as the project director during the first year and was contracted with through the National Rural Health Resource Center. As an expert in the area of rural health and his involvement in other related projects, Terry's contribution to the political arena proved important. Christy Crosser, employed by Mountain States Group served as the associate director and assisted with project management. Brian Haapala served the role of a contracted hospital

consultation expert, guiding the project's direction based on experience and significant involvement in the project's daily work and details.

The project was represented at a HRSA meeting on September 20, 2001, in Rockville, Maryland. Representatives and included Terry Hill, Hartzell Cobbs, Val Schott and Christy Crosser. This meeting initiated the project and provided an opportunity for project representatives to review the submitted proposal and make recommended changes to the HRSA staff.

A project team meeting was held in Duluth, Minnesota on October 10 and 11, 2001. During this meeting, significant discussion took place regarding the project's management plan. This is when the state meetings started to be developed.

Project staff meet weekly via conference calls early in the project and then later evolved to every two weeks. Hartzell started to be on the project's administrative conference calls later in the contract year.

A project administrative team meeting was held August 2002 in Boise, Idaho. This meeting proposed to review the first year activities and to plan for the second year.

Task 2: Establish Advisory Group
With guidance from the PO, the Contractor shall establish an advisory committee and provide it with logistical support. Committee will meet on a quarterly basis by phone.

Project staff and representatives decided early in the project and as reported in the first quarter progress report, to establish state advisory groups in each of the eight states in the Mississippi River Delta Region. The project found that the state-level organizations had important information and perspectives regarding how the project could best be implemented in their respective states and establishing these advisory groups, the project ensured greater success.

The lead agencies for these groups are the state offices of rural health and the state hospital associations. The state advisory groups had the following responsibilities:

1. served in leadership roles for the state meetings, including the project informational meetings;
2. serves in an advisory capacity to project staff;
3. assisted with prioritizing hospital participation (selection of hospitals to participate in on-site technical assistance);
4. provided project marketing (reaching eligible hospitals to inform them about this project, and about its opportunity and benefits).

The first state meeting was held during the first quarter, on November 7, 2001 in Illinois. The project went to all the states for an informative meeting.

- Alabama – January 7, 2002
- Arkansas – January 22, 2002

- Illinois – December 7, 2001
- Kentucky – January 15, 2002
- Louisiana – December 18, 2001
- Missouri – February 6, 2002
- Mississippi – December 19, 2001
- Tennessee – January 16, 2002

The project advisory committee was established during the third quarter of this project. The list is appended. Two conference calls were held with the project advisory committee: June and August 2002. Notes from these conference calls were previously submitted in the fourth quarter progress report and are available upon request.

Task 3: Develop Services and Capabilities
A. The Contactor shall develop a tool for assessing the current financial and operational performance of a small rural hospital. Key elements of this tool shall include, at a minimum, cost accounting, medical practice management, managed care contracting, financial planning (budgeting), coding, staffing, and monitoring. The tool should be accessible through a variety of media, e.g., web-based or printed versions.

A Standard Data Request Scope of Services was used combining tools from the evaluator and the Stroudwater Associate consultants. This assessment tool, used with the comprehensive consultations is extensive and was clearly a valuable tool as it provided significant information prior to the on site consultation visits. Several hospitals noted that they were impressed with the preparation of the consultations.

The comprehensive consultations performed by Stroudwater Associate's strategic planning and performance improvement services began with a review of the hospital's historical data followed by an intensive, on-site analysis of its programs, strategic options, operations and staffing. The site analysis included interviews with hospital board and management leadership, physicians and departmental staff. A comprehensive written report of findings and recommendations was presented to key stakeholders determined by the hospital, with opportunities for questions and dialogue. Stroudwater Associate consultants made every effort to be available to provide follow-up during the first year, according to the project's resources and as requested by the hospital administration.

Objective: The objective of the strategic planning/ performance improvement engagement was to conduct rapid, focused analyses of the hospital and its market that resulted in the identification of concrete opportunities for clinical service line, operational and financial performance opportunities. This was completed within the context of enhancing and sustaining the critical role of the organization in its rural community.

Specific approach and work plan: The major areas of emphasis in the strategic planning/ performance improvement analysis included the following:

- Analysis of service area population characteristics and trends
- Review of clinical service programs comparing hospital programs to community need, as well as other rural hospitals
- General review of finance functions including third-party contract strategies, availability of decision support information, etc.
- Review of Medicare and Medicaid use reports to ensure optimal reimbursement
- Benchmarking of hospital expenses with peer hospitals
- Physician practice management assistance
- Review of organizational architecture and general management principles

The work plan for this initial assessment and consultation was divided into four phases.

- Stroudwater Associates began the strategic planning/ performance improvement engagement with interviews of key staff by telephone. The purpose for this was to prepare for the on-site consultation. This initial step consistently achieved a high level understanding of the breadth of services, as well as the community's requirements and expectations of the facility. The consultants then explored areas where the current hospital leadership believed there were improvement opportunities, and gather the data available this analysis.

- Because the on-site time was designed to engage the administration, physicians, board and staff on key hospital issues, it was important that data was received in advance. Data required before the on site visit included historical operations and financial.

- Following a thorough review of hospital data, Stroudwater Associates would work with the administration to schedule a site visit to interview key staff, board members, community representatives and providers (including specialty physicians who provide services at the hospital), observe key processes and procedures, and interact with the administrator and others as recommendations are considered.

- Findings from the site visit would then be presented in preliminary form at an exit interview with the administrator and invited members of the staff. A summary written report always followed in approximately three weeks and would take the form of a strategic/ performance improvement plan which included recommended goals, action steps, and realistic, attainable, improvement targets in key performance areas. The format would be customized to meet the hospital's needs and all hospitals are provided the opportunity to comment on the plan.

Proposed Interview Schedule

- Joint and individual interviews were be held with the administrator, senior management team, employed primary care physicians and other medical staff, board representatives and others as recommended by the hospital administrator. A tour of the facilities was also taken.
- Clinical and service interviews were held with the manager or lead staff in each clinical department, non-hospital primary care physicians, specialty and consultant providers, visiting consultants, and others is indicated.

- Data, operational and financial focus interviews were held with CFO/ controller, key business office staff, physician practice manger and key operational staff in medical offices.

For targeted consultations, consultants contacted the hospitals, state partners and if appropriate or possible, community network grantees in the area. Besides assessment being conducted through contacts, consultants would use their own tools as appropriately. What these tools focused on depended on the consultation.

Oklahoma State University was subcontracted to develop tools. During the first year of the project, no tools were completed. The following is a progress report from Oklahoma State University regarding tools development.

> Kidney Dialysis Guidebook. The background research for this guidebook is complete and the first draft completed June 2002. The document will allow a community to estimate the demand for the service as well as cost, revenue, and profit (if positive) for a facility.
>
> Emergency Medical Services. Plans for a first draft of this guidebook by the end of July 2002. This is an update of a previous guidebook.
>
> Rural Health Clinic. Plan to build this guidebook to review all components of a federally qualified health center. Modules for physician services, dental services, mental services, and pharmacy. End of the summer 2002.
>
> Assisted Living. The guidebook will allow community leaders to estimate demand, costs, revenues and profitability of a proposed facility. Completed by end of summer 2002.
>
> All tools will have guidebooks and spreadsheets for ease of application.

An inventory of tools was started late October 2001, and continues to date. This ongoing process includes an announcement on the project's web site for consultants and organizations to submit tools.

The Contractor shall also provide a national information and database describing the performance of small rural hospitals that can be used as a benchmark by client hospitals.

The first year resulted in significant decisions regarding benchmarking and the Balanced Score Card project.

Benchmarking will be one of the process tools that will assist hospitals in improving performance. Significant work was started during the first contract year research feasibility of using the Balanced Score Card performance measurement model. Contracts were developed with two national firms – Practicing Smarter and Stroudwater Associates to implement a Balanced Scorecard in at least two Mississippi Delta hospital sites. The first two sites will be in rural hospitals in Arkansas and Mississippi.

Plans are also underway to build a hospital performance database that will enable Delta hospitals to benchmark performance with other Delta hospitals and help to drive each hospital's strategic performance. Additional resources will be necessary to achieve a significant Delta database.

Performance measurement training has also been planned for each participating hospital, and to the degree possible with each participating state. A two day meeting of hospital and state people in October 2002, outside of Memphis, Tennessee began the performance measurement education process. Participants generally indicated an enthusiasm for moving forward with performance measurement activities.

The second year will bring significant work in the areas of performance improvement using the Balanced Scorecard. Two pilots hospitals will be participating.

B. Contractor shall develop a process tool that will help client hospitals develop a comprehensive strategic plan for improving their performance and defining an appropriate mix of health services. The tool will address, at a minimum, the following:

- *Financial and operational performance (see A above).*
- *Quality of clinical care. To include regulatory and accreditation-based standards, patient satisfaction surveys, clinical outcomes, etc.*
- *Staff recruitment and development. To include physician and nurse recruitment and retention, workforce planning, and staff and leadership development.*
- *Access to information, technology and capital. To include data collection, development of information capabilities, access to needed technology and access to capital for equipment and construction.*
- *Community relations and networking. To include community development, marketing and provider networking.*

A step-by-step outline was designed regarding the consultation process and includes initiation through implementation, follow-up and sustainability. This information is detailed for hospital administrators to clearly understand the process steps and to help them make an informed decision about their participation and preparation. The process includes outcomes.

A variety of performance improvement approaches were used as it is believed that no one method could meet the needs of all the client hospitals. Among those important to the project is the Baldrige National Quality Program. Basic principles for this project included hospital

leadership development; patient-focused care; staff involvement; systems approach; and management based on data.

The comprehensive performance improvement process was designed for faster continuous improvement and used a variety of tools. The idea was to blend continuous improvement into a single change management system, with tools available to facilitate the process.

The transfer of knowledge and processes was a people-to-people relationship and the consultants selected were on-site working directly with the hospitals. The performance improvement process succeeded when there was a personal and organizational willingness to learn.

1. This process started with planning (initiate process), and relationship building, definitions were established, and key measurements determined.

2. The second phase was collecting information prior to the on-site visit. Quantitative data provided the foundation for qualitative data that was collected during the on-site visit.

3. During the on-site consultation, key activities often led to information in trends and identifying practices that worked and those that needed improvement. The face-to-face visits allowed for insights on the actual practices taking place in the hospital that impact the overall performance. Information was also obtained about the community and its impact on the hospital and health care system.

4. Discussion about key findings determined an immediate plan-of-action; those short-term implementation activities that can make a difference quickly. The consultants helped to facilitate the hospital team to develop this immediate plan, and to adapt and implement what they had learned.

5. Adaptation and improvement are often the greatest challenges for these small rural hospitals. It is sometimes easy to return to the comfort of doing what they have always done before. Building local capacity and providing continuous follow-up, even if a telephone call to check in, made a difference in the sustainability of the performance improvement.

C. The Contractor shall describe the anticipated number of facilities the Contractor can assist within the scope of its capabilities.

The project planned to visit ten hospitals to deliver comprehensive consultation. Nine were realized as the tenth consultation was canceled due to a change in the hospital management. The tenth hospital was scheduled, preliminary information was acquired, and then the consultation cancelled.

Between ten and fifteen hospitals were originally projected for targeted consultation. Thirteen were started and three completed during the first year. Targeted consultations were found to take

longer than expected to implement, as the hospital and the state partners participated in the consultant selection process, and consultations sometimes required extra time because of the hospital's desire to move slowly.

Task 4: Develop and Implement a Marketing Plan

The Contractor shall develop and implement a marketing plan for informing small rural hospital in the Delta region about the availability of the HPI Initiative. This plan shall include a strategy for encouraging hospital participation including a demonstration of their commitment (match, in-kind contribution, etc.). Plan shall take into account the capacity of the Contractor to respond. The Contractor will describe how clients will be selected from eligible applicants.

As indicated earlier project personnel made visits to each of the eight states to market the project in person. Groups of hospital administrators and state hospital association and state office of rural health personnel were in attendance at scheduled meetings in each state.

The state offices of rural health and state hospital associations were used to market this project resulting in various measures of success depending on the state. Marketing started with the state meetings and continued through conference calls with project team members. Information was sent to the state partners, including a project description and list of eligible hospitals. State partners also received regular update regarding applications received. Copies of applications were sent to the state partners.

Most of the state hospital associations and state offices of rural health took a lead during the first year to market this project to eligible hospitals. Where this was not done, the project team took the initiative. Project team members also took advantage of marketing the project and informing others regarding the project at various meetings:

Office of Rural Health Policy's Mississippi Delta Rural Development Networks Grantees Meeting, November 29 and 30, 2001, in Memphis.

National Rural Health Association Annual Meeting, May 2002, Kansas City.

Secretary's Advisory Committee on Regulatory Reform in Pittsburgh, Pennsylvania on April 17 and 18, 2002.

Briefing to HRSA executive team April, 2002.

Presentation to the Illinois Hospital Association in November, 2001.

Presentation at the 2002 national Flex Educational Conferences in Washington DC in March, 2002.

Presentation at the Minnesota Rural Health and Development Conference in July, 2002.

Presentation at the Alaska Hospital Conference in May, 2002.

Presentation at the Hawaii Flex Conference in September, 2002.

Presentation at the Arizona Conference in August, 2002.

Presentation at the national quality meeting in Minneapolis, Minnesota in October, 2002.

Notes and lists of participants for most of the meetings are on the project's web site, and submitted with the quarterly progress reports.

An agenda was developed for the state meetings; however, the meetings were tailored for each state and their needs and participants. The state meeting agenda included presentation and discussion regarding the following:

1. Partnerships
2. Supporting performance improvement (PI) development
3. Historical challenges
4. Focus on long term success
5. Federal support
6. Project goals
7. Guiding principles
8. Project components
9. Performance improvement process (PI)

Additional agenda items included: the role of the state organizations and information on the application process.

Terry Hill, Project Director, presented at the state meetings, which were considered information and provided an opportunity to market the project's services. The slide presentation in included on the web site and was previously submitted in a quarterly report.

Another part of the state meetings, was the presentation regarding community engagement. Val Schott (Oklahoma Office of Rural Health) and Gerald Doeksen (Oklahoma State University) presented on the Importance of the Health Care Sector on the Economy, Strategic health planning process and Budget studies needed in the health planning process.

State hospital associations and state offices of rural health were generally instrumental in their leadership roles for informing eligible hospitals about the state meetings, the project, and the application process and implementation. The project experienced cooperation and support in most of the states with both the offices of rural health and the hospital associations. In some cases the state meetings brought these two organizations together for a common cause to help the rural hospitals in the Mississippi Delta Region.

The application process provided another early opportunity to market the Delta RHPI Project. An introductory memo to the state offices of rural health and hospital associations. Included with this memo was a draft memo, tailored to each state to send to the eligible hospitals with the application form (on the web site and previously submitted). During this time, the project team listened to the state representatives and their feedback on the application process and form. The feedback received during the first contract year was that the application form and process was easy to follow and complete.

It was determined that the criteria for participation included 1) geographical location of the hospitals, within the define Mississippi Delta Region according the Delta Regional Authority, and 2) the hospital must have fifty (50) or fewer staffed beds. However, limited resources required a selection process and the list of considerations was developed.

Delta Rural Hospital Performance Improvement (RHPI) Project
Hospital Participation – Application Process Considerations

The following is a list of considerations for selecting hospitals to participate in targeted or comprehensive performance improvement consultations:

* Presentation of a completed application and a letter of invitation from the hospital administrator and board chair (or designee). Resources are limited and those hospitals that present the information in a timely manner will be considered first.

Demonstration of a need for technical assistance in the application and through the follow up interview(s).

Equity among the eight states so that each state receives a proportionate share of available resources and services.

Demonstration of:
- Willingness to participate in the performance improvement process;
- Willingness to examine current hospital performance and to consider strategies for improvement;
- Willingness to engage fully in change processes; and
- Willingness to share data and information with consultants.

Recommendation from the state hospital association and/ or the state office of rural health that the hospital is a good candidate and would benefit from this service.

Determination that there is a good fit between the resources and resource people available, and the applicant hospital. In addition, determination that the timing is right.

The project staff for the Delta Rural Hospital Performance Improvement Project reserves the right to make the final decision on choice of hospital participants.

Using these considerations were part of what the hospital would contribute along with time for the preparation and on site consultation, and the implementation of recommendations.

The application memos and forms were distributed to all the states and/ or directly to the hospitals by the end of January 2002.

Offices of rural health and hospital associations took on various roles to progress the application process.

Task 5: Identify and Train Consultant Team
The Contractor shall identify expert consultants who can provide on-site, technical assistance to client hospitals. Such technical assistance shall include working with individual hospitals to (1) complete the assessment and performance survey; and (2) develop a comprehensive strategic plan.

The Contractor shall train this cadre of consultants in the use of the assessment performance survey and strategic planning tool developed under Tasks 3A and B.

The comprehensive performance improvement on-site technical assistance was conducted by the Stroudwater Associates, which already had extensive experience in hospital performance improvement in the eight state area. Stroudwater Associate's experience in assisting hospitals with strategic planning, service line development, operational assessment, financial review and provider issues creates a value to this project. Training was not needed for the selected consultants and new consultants that Stroudwater included were trained by the more experienced consultants and provided opportunity to go on site to learn about the process.

The targeted performance improvement technical assistance used consultants chosen jointly by the RHPI Project and the participating hospital, along with the state partners. The RHPI Project drew consultants from other programs and continued to build a list of consultants through the year. Consultants were provided information regarding the project and its stated goals, processes and desired outcomes.

The comprehensive consultations include an assessment tool for gathering data and information. This information is used in advance of the on site consultation visit by the consultants and results in consultants who are very well prepared, knowledgeable about the hospital and able to focus their time on issues that impact performance. Consultants are trained to look beyond the data and information, be open to possibilities that might arise while on site, and the be flexible with their on site visit to maximize the time together.

Targeted consultation still requires an assessment and varies depending on the focus of the consultation, need of the hospital and the consultant. The RHPI Project has found that allowing consultants to work with the tools they are most familiar with is effective. The tools may vary from formal assessment surveys such as what was used with Caldwell Hospital in Kentucky for

the information systems consultation to a variety of tools for assessing staffing ratios and needs currently taking place in Humboldt General Hospital in Tennessee. The assessment process for target hospitals may also be less structured such as what happened with Ferrell Hospital in Illinois, looking at various resources for productivity.

All consultations, comprehensive and targeted, resulted in reports or plans. The reports included general background information, supporting documentation and recommendations. The process generally followed was that the consultants presented a draft report to the hospital administrator, who edited it. A final report was presented and in some cases another site visit took place to represent the results, often to the board and/ or management staff.

The current list of consultants on the list for this project is 18 for targeted consultations.

It is anticipated that additional consultants may be added as targeted consultations continue and the project plans to arrange a conference call with the consultants to discuss the project, consultation process and needs.

Task 6: Deliver On-site Technical Assistance

Contractor shall arrange and schedule all on-site technical assistance by consultant experts. Such assistance shall include working with the hospital to: (1) complete the assessment and performance tool; and (2) develop a comprehensive strategic plan. It is anticipated that each hospital will be provided a total of 10-15 consultant days with the majority on-site. Site visit team should, based on individual circumstance, include expert consultant, Contractor staff, representative from the SORH or state hospital association and community leadership.

It is anticipated that approximately 25-30 hospitals will receive assistance under this contract during year one and about the same in each during year two and three.

The first comprehensive consultation was conducted January 2002. Ten consultations were scheduled and nine implemented. A tenth comprehensive consultation was cancelled due to a change in the hospital management system.

Hospitals participating in the comprehensive consultation completed an assessment tool working closely with the consultants from Stroudwater Associates and included the collection of data. The data was sent to the consultants in advance of the site visit and consultants were well prepared to use the time at the hospital effectively and efficiently.

The first agreements for targeted consultations were finalized June 2002 with consultations starting in July. These vary in scope and time frame. Most required two visits, early in the consultation process to gather information and then another visit to present the result (report), sometimes to the board.

The process for scheduling the targeted consultation was found to have a longer lead time because consultants had to be selected with input from various individuals (the hospital administrator and state partners). Conference calls between the administrator and potential consultants were often scheduled, adding more time to the selection process, but ensuring that there would be a match between the two. Though a longer time frame was needed to implement the targeted consultation, the results have been positive: a good match, consultants who have been effective in working with the hospitals, and reports that have been initially useful. Contact with the consultants and hospital administrators from the project associate director were conducted throughout the process; and following the consultation report completion, follow-up continued by telephone regarding the implementation of recommendations.

All participating hospitals were invited to participate in two surveys: employee satisfaction and prelude to strategic planning checklist.

For targeted consultations, it was not clear of their participation level with respect to assessment tools and follow-up. This will continue to be discussed as the project develops.

All consultations resulted in reports (strategic plans) that included background information and recommendations with supporting documentation, data and observations.

The number of on site days varied and tailored to the consultation needs and the hospital. To minimally disrupt the hospital operations, on site consultation were scheduled appropriately to meet the greatest number of people, conduct interviews and gather the information needed to assess the hospital's performance.

For all the consultations, the state partners, state offices of rural health and hospital associations, were contacted to provide them consultation information and updates. For comprehensive consultations, state partners were invited to attend the on site visit. For targeted consultations, consultants were expected to contact the state partners to discuss the consultation, and collect data and information.

During the first year, a total of 22 hospitals participated directly in this project with varying completion dates (some continuing into the second contract year). Considering the fact that this started January 2002, (January for comprehensive and July for targeted consultations) this is extremely successful and testifies to the needs and interest.

Task 7: Assist with Implementation of Strategic Plan
Contactor shall provide follow-up assistance to the hospital and community as they implement their strategic plan. Assistance shall include follow-up site visit, application of the tools developed under Task 3, telephone consults, online education, etc.

An important part of this project is building local capacity. The project discovered that building capacity is defined broadly, and a consultation results in capacity enhancement and expansion

with the hospital, the community, state and the region. The project also discovered that building capacity means sensitivity to existing limitations; meaning it may not be formal or readily apparent that capacity has improved.

The project opened the consultations up for state partners to participate and of course some chose to be involved while others did not.

By the end of the project year, it was apparent that more structure was needed for the second year to conduct follow-up. A plan was discussed and will be implemented. It is anticipated that this will positively impact the goal toward performance improvement.

Task 8: Develop Quality Management Process and Design Program Evaluation
Contactor shall develop and implement effective quality management system for consultant experts.

The Contractor shall develop and implement an evaluation plan for measuring performance with each client hospital and the entire HPI Initiative.

Consulting agreements were established with National Rural Health Resource Center and Stroudwater Associates. Subcontract was arranged with Oklahoma State University.

The National Rural Health Resource Center (NRHRC) is involved in several related and important projects including the State Flex Program and TASC. Stroudwater Associates is a leading consulting agency with significant experienced in providing hospital performance improvement services. Oklahoma State University with its Rural Health Works has experience in developing tools.

For those consultants not affiliated with these institutions, the project has drafted a negotiated written agreement and processes to help in ensuring that the project is recruiting quality and qualified consultants for targeted consultations. The process includes seeking consultants through reliable referrals and resources, checking references, conducting telephone interviews and providing an opportunity for input from the hospital administrators and state partners.

Amy Hagopian presented the project's evaluation plan from the University of Washington. Apparently, there was some confusion if this was an individual project effort with Amy or an institutional effort with the university. This was never resolved and resulted in a minimal effort. Mountain States Group revisited the evaluation component late in the project's first year and a part of it was continued and developed.

Eight hospitals participated in the project's employee satisfaction and the prelude to strategic planning surveys. Amy Hagopian distributed the surveys and she collected the data. Data was input into a spreadsheet. This information was then forwarded to Mountain States Group where Linda Powell drafted a report. Working with Christy Crosser and Brian Haapala, a final report

format was determined and eight reports for the participating hospitals were quickly completed and distributed.

The prelude to strategic planning survey was later found to be used in conjunction with other evaluative tools, which were never implemented for this project. It is yet to be determined if the data from these surveys will be useful for those hospitals who completed these.

Linda Powell and Christy Crosser worked together to develop a follow-up survey tool that Mountain States Group distributed to participating hospitals, consultants and the state partners. This effort will continue with surveys sent to hospitals and consultants one month following completion of the consultation.

2) ANY PROBLEMS ENCOUNTERED AND PROPOSED SOLUTIONS

One of the identified problems was that people got the RHPI project confused with the Delta community networking project. Though there were numerous attempts at clarifying the project work, some of the confusion remained.

Developing the eligible hospital list also presented challenges. There was no structure to adding hospitals, confusion regarding the criteria (staffed verses licensed beds), and agreed upon resources for determining eligibility.

One of the challenges was in project start up, with some events occurring later in the contract year than at first anticipated. The first comprehensive consultations were conducted in January 2002, and the targeted consultations began in July 2002.

A second and significant challenge was with the evaluation component. The original plan was ambitious, and might have been difficult to achieve under the best of circumstances. A modified plan was developed and implemented with the help of Linda Powell

Another challenge was that there was ambiguity as to expectations for some of the key individuals working on this project. This led to even further challenges of communication, complicated by distances between participants and competing schedules and obligations.

State partners varied in their support and involvement. The project found it necessary to take a lead role in marketing the project to rural hospitals and to conduct follow up for participation. The amount of effort in some states has been significant.